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Office of Administrative Law Judges
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Issue date: 07Nov2000

CASE NO.: 1995-BLA-01447

In the Matter of:

GROVER MUNCY
Claimant

v.

WOLF CREEK COLLIERIES
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

DECISION AND ORDER ON REMAND DENYING BENEFITS

Procedural History

This proceeding arises from a claim filed by Grover Muncy for benefits under the Black Lung Benefits Act of 1977, 30 U.S.C. §901, et. seq., as amended. Claimant initially filed his claim on March 4, 1994. On January 10, 1997, the undersigned issued a Decision and Order Awarding Benefits. The Decision and Order stated that the medical opinion evidence of record was sufficient to establish pneumoconiosis under §718.202(a)(4). The Decision and Order also stated that Claimant was entitled to the rebuttable presumption under §718.203(b) that his pneumoconiosis arose out of coal mine employment and that this presumption had not been rebuttted. The undersigned further determined that Claimant was totally disabled due to pneumoconiosis pursuant to §718.204(b), (c).

Employer appealed the January 10, 1997, Decision and Order Granting Benefits to

the Benefits Review Board (the "Board"). In its appeal, Employer challenged the undersigned's findings under §§718.202(a)(4) and 718.204(b), (c)(4). Employer argued that these findings were made without consideration of Dr. Dahhan's medical opinion which was contained in Employer's Exhibits (EX)[1] 3-28. The Board affirmed in part, vacated in part, and remanded the case for "reconsideration and/or to allow the administrative law judge to provide reasons for excluding and/or not considering Employer's Exhibits 3-28." The Board also instructed the Administrative Law Judge to reconsider all of the relevant medical opinion evidence of record under §§718.202(a)(4) and 718.204(c) and if reached on remand to weigh all of the relevant evidence pursuant to §718.204(b), (c)(4). *Muncy v. Wolf Creek Collieries,* BRB No. 97-0690 BLA (Dec. 22, 1997)(unpublished).

The Decision and Order that this appeal is predicated upon was issued on November 4, 1998. On November 4, 1998, the undersigned issued a Decision and Order on Remand Awarding Benefits to Claimant. That Decision and Order did not consider Employer's Exhibits 3-28 because although the exhibits had been admitted at the hearing, they were missing from the record and Employer's counsel did not respond to the undersigned's requests for copies of them. In the November 4, 1998, Decision and Order, the undersigned also determined that Claimant established the existence of pneumoconiosis under §718.202(a)(4), the presumption of pneumoconiosis arising out of coal mine employment pursuant to §718.203(b), and total disability due to pneumoconiosis under §§718.204(b), (c)(4).

Employer appealed the November 4, 1998, Decision and Order to the Board. In its current appeal, Employer argued that the case should be remanded for the administrative law judge to consider Employer's Exhibits 3-28. Employer further asked the Board to reconsider the undersigned's weighing of the evidence under §§718.202(a)(4) and 718.204(b), (c)(4), as well as the finding regarding the date from which benefits began.

In a Decision and Order dated June 30, 2000, the Board affirmed in part, vacated in part, and remanded the case for further consideration consistent with the Board's opinion. The Board's Decision and Order stated that "fundamental fairness mandates remanding this case to the ALJ for consideration of [Employer's Exhibits 3-28]." Specifically, the Board stated that Dr. Dahhan's medical report (EX 3) must be considered when weighing the evidence under §§718.202(a)(4) and 718.204(c), (b). In addition, the Board vacated the undersigned's finding that the evidence was sufficient to establish total disability under §§718.204(c)(2) and (c)(4). Specifically, the Board stated the undersigned did not weigh the qualifying blood gas study against the two non-qualifying studies or the other contrary evidence under §§718.204(c)(1)

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[1]The following references will be used herein: "DX" designates Director's Exhibits; "EX" designates Employer's Exhibits; "ALJX" designates Administrative Law Judge exhibits.

and (c)(4). The Board also vacated the finding of total disability under §718.204(b) and remanded for reconsideration of all relevant evidence if reached. Finally, the Board has asked the undersigned to review the evidence to determine whether medical evidence established when the miner became totally disabled due to pneumoconiosis.

Issue

This case presents the following issues for review:

1. Whether Claimant is totally disabled due to pneumoconiosis under §718.202(a)(4) and §§718.204(b) and (c)?

2. Whether medical evidence established when the miner became totally disabled due to pneumoconiosis.

Findings of Fact

Claimant was born on February 12, 1938. Claimant is married to Delma Harmon, who is his only dependent for purposes of augmentation of benefits under the Act. At the May 23, 1996, hearing, the parties stipulated to twenty-nine years of coal mine employment.

Medical Evidence

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis: (1) x-rays interpreted as positive for the disease, (2) biopsy or autopsy evidence, (3) the presumptions described in §§718.304, 718.305, or 718.306, if found to be applicable, or (4) a reasoned medical opinion which concludes the presence of pneumoconiosis, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examination, and medical and work histories. The Board has asked the undersigned to review the finding that Claimant has established pneumoconiosis pursuant to §718.202(a)(4). In particular, this review is to include the medical opinion of Dr. Dahhan. (EX 3). However, in order to provide a complete analysis of Claimant's claim, this opinion considers all of the relevant medical evidence of record.

Chest X-Ray Evidence

Under §718.202(a)(1), a finding of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with §718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according

to the ILO-U/C classification system. A chest x-ray classified as category 0, 0/1, 0/0, or 0/- is not evidence of pneumoconiosis.

Chest x-ray interpretations relevant to the determination of whether Claimant has pneumoconiosis were submitted into evidence. The following is a list of the x-ray readings and the names and qualifications of the interpreting physicians.

EX. No.	Doctor	Credentials	Date of X-Ray	Date of Reading	Reading
DX 15	Wells	NL[2]	6/30/93	7/20/93	2/1
DX 15	Skolnick	BR[3]	6/30/93	4/1/94	1/0
DX 15	Clarke	NL	7/6/93	7/6/93	2/1
EX 1	Broudy	BCI[4]-BCP[5]	10/13/93	10/13/93	no pneumo
DX 10	Younes	BCI-BCP	6/10/94	6/10/94	0/1
DX 13	Ranavaya	NL	6/10/94	6/13/94	0/1
DX 12	Sargent	BR-BCR[6]	6/10/94	7/19/94	no pneumo
EX 4	Dahhan	BCI-BCP	11/4/95	11/05/95	0/0

[2]The symbol "NL" indicated the physician's credentials are not listed on the x-ray report nor otherwise indicated in the record.

[3]The symbol "BR" denotes a physician who was an approved "B-Reader" at the time of the x-ray reading. A B-Reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupation Safety & Health, U.S. Public Health Service, pursuant to 42 C.F.R. §37.51 (1982).

[4]The symbol "BCI" denotes a physician who has been Board Certified in Internal Medicine.

[5]The symbol "BCR" demotes a physician who has been Board Certified in Radiology or Diagnostic Roentgenology.

[6]The symbol "BCP" denotes a physician who has been Board Certified in Pulmonary Medicine.

ALJ 1	Guberman	BCI-BCV[7]	6/21/96	6/21/96	no pneumo
ALJ 1	Rubenstein	BR-BCR	6/21/96	6/21/96	0/1

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. §718.202(a)(1); *Dixon v. North Camp Coal Co.,* 8 BLR 1-344 (1985). The Administrative Law Judge may assign more weight to the x-ray interpretation of a B-Reader. *Aimone v. Morrison Knudson Co.,* 8 BLR 1-32 (1985). The interpretation of an x-ray by a physician who is a Board Certified Radiologist as well and a B-Reader may be given more weight than the interpretation of a physician who is only a B-Reader. *Scheckler v. Clinchfield Coal Co.,* 7 BLR 1-128 (1984). Where there is conflict among identically qualified readers, as the trier of fact, the Administrative Law Judge must resolve it. *Dees v. Peabody Coal Co.,* 5 BLR 1-117 (1982).

In this case, the x-ray evidence fails to establish that Claimant suffers from pneumoconiosis. The majority of readings of record by Board Certified Radiologists and B-Readers were negative for pneumoconiosis. There is one positive reading in the record by a B-Reader, Dr. Skolnick. However, I do not credit Dr. Skolnick's positive reading in light of the two negative readings by two physicians whose credentials surpass those of Dr. Skolnick, Dr. Sargent and and Dr. Rubenstein, both of whom are B-Readers and Board Certified Radiologists.

Biopsy or Autopsy

Pursuant to §718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. This method of proving the existence of pneumoconiosis is unavailable in the instant case because the record contains no biopsy evidence and because Claimant is alive. Thus there can be no autopsy evidence.

Presumptions

Pursuant to §718.202(a)(3), a determination that a claimant suffers from pneumoconiosis may also be shown using the presumptions described in §§ 718.304, 718.305, or 718.306. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 applies only to claims filed before January 1, 1982. Because this case was filed after that date, the §718.305 presumption is inapplicable. Section 718.306 is only applicable in the case of a

[7]The symbol "BCV" denotes a physician who has been Board Certified in Cardiovascular Medicine.

deceased miner. Thus, the §718.306 presumption is not applicable either. Therefore, because none of these presumption are applicable, the Claimant cannot establish the existence of pneumoconiosis pursuant to §718.202(a)(3).

Medical Opinions

The fourth way to establish the existence of pneumoconiosis under §718.202 is set forth in subparagraph (a)(4). A determination of the existence of pneumoconiosis may be made, notwithstanding a negative x-ray, if a physician, exercising sound medical judgment finds the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence, such as arterial blood gas studies, pulmonary function studies, physical examinations, and medical and work histories. Such a finding must be supported by a reasoned medical opinion.

The following doctors' medical reports were submitted to the record: Dr. W.F. Clarke (DX 15), Dr. Gregory Wells (DX 15), Dr. Bruce Broudy (EX 1), Dr. Maan Younes (DX 10), Dr. A. Dahhn (EX 3), and Dr. Bruce A. Guberman (ALJx 1). These reports are summarized below.

Dr. Clarke examined the Claimant on July 6, 1993. At the time he prepared that report, he had 48 years of medical experience working with coal miners. Dr. Clarke diagnosed Claimant with pneumoconiosis. He concluded that Claimant was totally and permanently disabled for all work in a dusty environment and all manual labor due to pneumoconiosis. His thorough examination revealed an increased chest diameter, and bilateral rales and rhonchi. He also noted a shortness of breath and dyspnea after walking and climbing. Dr. Clarke also took into consideration Claimant's 29 years of coal mine employment and absence of a smoking history. As part of the examination, Dr. Clarke administered a pulmonary function study with the following results: FEV1- 3.2; FVC 4.37; MVV- no value included in the record; Cooperation- good. These results are not qualifying under the Act. Dr. Clarke also took a chest x-ray which he read as positive for pneumoconiosis.

Claimant was examined by Dr. Wells on July 20, 1993. Dr. Wells' credentials are not contained in the record. Dr. Wells diagnosed Claimant with both pneumoconiosis and emphysema and opined that he is totally and permanently disabled from returning to work in a dusty environment due to his respiratory condition. In his report, Dr. Wells considered Claimant's symptoms, including shortness of breath when walking 200 yards or one flight of steps, a dry cough, and three-pillow orthopnea. He also considered Claimant's 29 years of coal mine work and absence of a smoking history. Dr. Wells administered a pulmonary function test and reviewed a chest x-ray dated June 30, 1993. The pulmonary function study results were as follows: FEV1- 3.02; FVC- 3.31; MVV-56.5; Cooperation- good. These values are not qualifying. Dr. Wells interpreted Claimant's chest x-ray as positive for pneumoconiosis. This reading was later confirmed by Dr. Skolnick, a B-Reader.

Dr. Broudy examined Claimant on October 13, 1993. Dr. Broudy is Board Certified in Internal Medicine and Pulmonary Disease. He concluded that Claimant does not have pneumoconiosis and that he does have the respiratory capacity to perform work of an underground coal miner or to do similar manual labor. Dr. Broudy took a patient history indicating Claimant had worked in the coal mines for 29 years and that he was a non-smoker. He also administered a chest x-ray, a pulmonary function study, and an arterial blood gas test. Dr. Broudy did not find that the x-ray showed pneumoconiosis. The pulmonary function study results were as follows: FEV1- 4.83; FVC- 3.65;MVV- no value included in the record; Cooperation- good. These are not qualifying values. The arterial blood gas test produced the following results: pCO2- 39.1; pO2- 70.9. These results are non-qualifying. However, Dr. Broudy did note that the arterial blood gas study shows mild resting arterial hypoxemia. He also stated that the results of the spirometry and blood gas tests suggest that the dyspnea is non-pulmonary in origin.

Dr. Younes examined Claimant on June 10, 1994. He is Board Certified in Internal Medicine and Pulmonary Disease. Dr. Younes took a patient history which included Claimant's 29 years of coal mine work as well as his absence of a smoking history. He also administered a pulmonary function test and an arterial blood gas test. The results of the pulmonary function study were as follows: FEV1- 3.93; FVC- 4.82; MVV- 88; Cooperation- good. These values are not qualifying. The arterial blood gas study produced the following values: pCO2- 37; pO2- 77.7. These values are not qualifying under the Act. However, Dr. Younes found them to show that Claimant suffers from hypoxemia and is disabled.

Dr. A. Dahhan examined Claimant on November 4, 1995. Dr. Dahhan is Board Certified in Internal Medicine and Pulmonary Medicine. He concluded that Claimant does not suffer from pneumoconiosis. Dr. Dahhan took a patient history, including Claimant's 29 years of coal mine employment and absence of a smoking history. He administered an electrocardiogram, a pulmonary function study, an arterial blood gas study, and a chest x-ray. The results of the pulmonary function study were as follows: FVC- 4.43; FEV1- 3.41; MVV- invalid due to poor effort. These results are not qualifying. The results of the arterial blood gas study were as follows: pO2- 78.8; pCO2- 35.4. These values are not qualifying. In addition, Dr. Dahhan did not find any hypoxia. In reference to Dr. Younes' finding of hypoxia, Dr. Dahhan stated:

> [t]he previously reported hypoxia, if it was indeed present during Dr. Younes' examination, was not permanent since it was not present during my evaluation at rest or after exercise, indicating that it was not due to a fixed pulmonary disease, which would be the case in individuals with hypoxia secondary to coal mine employment. (EX 3).

Dr. Dahhan also explained that he was concerned that the sample of blood Dr. Younes tested

was not a pure arterial blood sample, but rather a mixed sample. In addition, Dr. Dahhan did not find the chest x-ray to be indicative of pneumoconiosis. He diagnosed Claimant with coronary artery disease with angina pectoris and cardiac arrhythmia.

Dr. Guberman examined Claimant on June 21, 1996. He is Board Certified in Cardiovascular Disease and Internal Medicine. Dr. Guberman obtained a patient history including Claimant's 29 years of coal mine employment and the absence of a smoking history. He administered a pulmonary function study and an arterial blood gas test. The results of the pulmonary function were contraindicated due to inadequately controlled fibrillation. The blood gas study produced the following results: pCO2- 38.8; pO2- 77.7. These results are not qualifying under the Act. However, Dr. Guberman found they indicated that Claimant is totally disabled from further employment in a dusty or dust free environment due to hypoxemia. Dr. Guberman opined that Claimant's 29 years of coal mine employment was the cause of his hypoxemia.

Issue 1: Whether Claimant is totally disabled due to pneumoconiosis under §718.202(a)(4) and §§718.204(b) and (c)?

Section 7(c) of the Administrative Procedure Act imposes the burden of persuasion on the party seeking the rule, in this case, the Claimant. Section 7(c) also requires the Claimant to meet his burden by a preponderance of the evidence, not by clear and convincing evidence. Accordingly, if the evidence is evenly balanced, the Claimant must lose. *Director, OWCP v. Greenwich Collieries,* 512 U.S. 267 (1994).

Entitlement to benefits under 20 C.F.R. §718 depends upon proof of three elements: (1) The claimant must establish he has pneumoconiosis, (2) his pneumoconiosis must have arose out of his coal mine employment, and (3) he is totally disabled due to pneumoconiosis. Pneumoconiosis must be a contributing cause to a miner's disability. *Scott v. Mason Coal Co.,* 14 B.L.R. 1-37 (1990) (*en banc, overruling Wilburn v. Director, OWCP,* 11 B.L.R. 1-35 (1988)). Section 718.201 defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." §718.201. Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis: (1) x-rays interpreted as positive for the disease, (2) biopsy or autopsy evidence, (3) the presumptions described in §§718.304, 718.305, or 718.306, if found to be applicable, or (4) a reasoned medical opinion which concludes the presence of pneumoconiosis, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examination, and medical and work

histories.

In addition to showing that he suffers from pneumoconiosis due to coal mine employment, a Claimant must show that he is totally disabled due to pneumoconiosis. Section 718.204 sets for the criteria for determining whether the miner is totally disabled due to pneumoconiosis. Section 718.204(b) provides:

> *Total disability defined.* A miner shall be considered totally disabled if the irrebuttable presumption in §718.304 applies. [If the irrebuttable presumption does not apply], a miner shall be considered totally disabled if pneumoconiosis as defined in §718.201 prevents or prevented the miner: (1) From performing his or her usual coal mine work; and (2) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time.

In addition, total disability may be shown by qualifying pulmonary function studies, qualifying blood gas tests, the existence of cor pulmonale with right side congestive heart failure, or the reasoned and medically supported opinion of a physician that the miner's pulmonary condition prevents him from performing his usual coal mine work. §§718.204(c)(1)-(5).

A finding of total disability may be made by a physician who compares the exertional requirements of the miner's usual coal mine employment against his physical limitations. *Cornett v. Benham Coal Co.,* ___ F.3d ___, Case Np. 99-3469 (6th Cir. 2000). However, the 6th Circuit requires that total disability be "due at least in part" to pneumoconiosis. *Adams v. Director, OWCP,* 886 F.2d 818, 825 (6th Cir. 1989). A claimant must prove more than a de minimis or infinitesimal contribution by pneumoconiosis to his total disability. *Peabody Coal Co. v. Smith,* 127 F.3d 504 (6th Cir. 1997). The miner must "affirmatively establish that pneumoconiosis is a contributing cause of some discernible consequence to his total disabling respiratory impairment." *Id.*

In the instant case, Employer has first challenged the undersigned's previous finding of pneumoconiosis by reasoned medical opinion under §718.202(a)(4). Section 718.202(a)(4) provides that the determination of the existence of pneumoconiosis may be made, not with standing a negative x-ray, if a physician, exercising sound medical judgment finds the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence, such as arterial blood gas studies, pulmonary function studies, physical examinations, and medical and work histories. Such a

finding must be supported by a reasoned medical opinion. Based on the medical report evidence provided, including Dr. Dahhan's medical report which was not taken into consideration when I issued my previous Decision and Order Awarding Benefits, I do not find that Claimant is totally disabled due to pneumoconiosis through reasoned medical opinion pursuant to §718.202(a)(4).

Dr. Clarke's July 6, 1993, medical report found the presence of pneumoconiosis based on an x-ray reading. Dr. Clarke is not Board Certified. He concluded that Claimant is totally disabled for all work in a dusty environment and manual labor. However, four of the six physicians whose reports were submitted in this claim opined that Claimant does not have pneumoconiosis. All of the physicians who found Claimant does not have pneumoconiosis have credentials that are superior to Dr. Clarke's. All are Board Certified in Internal Medicine, three of them are Board Certified in Pulmonary Disease, and one of them is Board Certified in Cardiovascular Medicine. Therefore, I do not credit Dr. Clarke's opinion.

Dr. Wells' July 20, 1993, medical report also found that Claimant has pneumoconiosis and that he is disabled by it. Dr. Wells is not Board Certified in any area. He read Claimant's chest x-ray as positive for pneumoconiosis. His x-ray reading was later confirmed by Dr. Skolnick who is a B-Reader. I do not credit Dr. Wells' report, however, because even though his positive x-ray reading was confirmed by Dr. Skolnick, the majority of B-Readers and/or Board Certified Radiologists who read Claimant's x-rays did not find them to show pneumoconiosis. In addition, four of the six physicians whose reports were submitted in this claim opined that Claimant does not have pneumoconiosis. All of the physicians who found Claimant does not have pneumoconiosis have credentials that are superior to Dr. Well's. All are Board Certified in Internal Medicine, three of them are Board Certified in Pulmonary Disease, and one of them is Board Certified in Cardiovascular Medicine. Therefore, I do not credit Dr. Well's opinion.

Dr. Broudy's well reasoned and detailed report opined that Claimant does not suffer from pneumoconiosis. He is Board Certified in Internal Medicine and Pulmonary Disease. Dr. Broudy relied on the results of Claimant's arterial blood gas study in concluding that Claimant has mild resting arterial hypoxemia and that his dyspnea is non-pulmonary in origin. He did not find that Claimant is disabled due to pneumoconiosis. I credit Dr. Broudy's report for the following reasons. First, Dr. Broudy is Board Certified in the areas of Pulmonary Disease and Internal Medicine. In addition, two of the three doctors who like Dr. Broudy concluded that Claimant does not have pneumoconiosis did conclude that he suffers from hypoxemia. Therefore, I credit Dr. Broudy's finding that Claimant suffers from hypoxemia, but not pneumoconiosis.

Dr. Younes' detailed and well reasoned medical opinion did not find that Claimant has pneumoconiosis. He is Board Certified in Internal Medicine and Pulmonary Disease. Dr. Younes concluded that the results of the arterial blood gas study show that Claimant suffers

from hypoxemia and that he is totally disabled. I credit Dr. Younes' report for the following reasons. First, Dr. Younes is Board Certified in the areas of Pulmonary Disease and Internal Medicine. In addition, two of the three doctors who like Dr. Younes relied on similar criteria and concluded that Claimant does not have pneumoconiosis, did conclude that he suffers from hypoxemia. Therefore, I credit Dr. Younes' finding that Claimant suffers from hypoxemia, but not pneumoconiosis.

Dr. Dahhan's medical report is also part of the record. He is Board Certified in Internal Medicine and Pulmonary Disease. Dr. Dahhan opined that Claimant does not suffer from hypoxemia or pneumoconiosis and that he is not disabled. In addition, Dr. Dahhan explained that in his medical opinion, if prior to his exam of the Claimant other doctors had found Claimant suffers from hypoxemia, it was not permanent because it was not present during his exam. Dr. Dahhan's credentials are excellent, his opinion is well reasoned and detailed, and I do credit his opinion that Claimant does not have pneumoconiosis. However, I do not credit it as conclusive that Claimant does not have hypoxemia or that the hypoxemia that may have been found in the Claimant prior to Dr. Dahhan's exam was temporary, because a subsequent exam performed by Dr. Guberman once again found hypoxemia.

The most recent medical opinion of record is by Dr. Guberman. Dr. Guberman examined the Claimant on June 21, 1996. Dr. Guberman is Board Certified in Cardiovascular Medicine and Internal Medicine. Dr. Guberman opined that based on the results of his arterial blood gas test, Claimant is totally disabled from further employment in dusty or dust free environments due to hypoxemia. He did not find that Claimant has coal miner's pneumoconiosis. I credit Dr. Guberman's opinion for the following reasons. First, Dr. Guberman is Board Certified in the areas of Pulmonary Disease and Internal Medicine. In addition, two of the three doctors who like Dr. Guberman relied on similar criteria and concluded that Claimant does not have pneumoconiosis, did conclude that he suffers from hypoxemia. Therefore, I credit Dr. Guberman's finding that Claimant suffers from and is totally disabled by hypoxemia, but not pneumoconiosis.

Although the evidence shows that Claimant suffers from hypoxemia, Claimant has failed to show by a perponderance of the evidence that he is totally disabled by pneumoconiosis as required by the Act. Although Dr. Younes, Dr. Guberman, Dr. Clarke, and Dr. Wells have found that Claimant is totally disabled and is not able to return to work in a coal mine or perform a similar job, this disability is the result of hypoxemia and not pneumoconiosis. Therefore, Claimant is not entitled to benefits because he has not shown that his total disability is "due at least in part" to pneumoconiosis as required by the 6th Circuit. *See Adams, supra.* Accordingly, because Claimant has not proven that he is totally disabled due to pneumoconiosis, he is not entitled to benefits under the Act.

2. Whether medical evidence established when the miner became totally disabled

due to pneumoconiosis.

Because the undersigned has concluded that Claimant is not totally disabled due to pneumoconiosis, the issue of whether the medical evidence established the date that the miner became totally disabled due to pneumoconiosis is moot. Therefore, this Decision and Order does not address that issue.

ORDER

The claim of Grover Muncy for benefits under the Act is, hereby, **DENIED**.

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PAUL H. TEITLER
Administrative Law Judge

Camden, NJ

NOTICE OF APPEAL RIGHTS: Any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board, Suite 500, 800 K. Street, N.W., Washington, DC 20001-8001. 20 C.F.R. §725.481. A copy of a Notice of Appeal must also be served upon Donald S. Shire, Esquire, Associate Solicitor for Black Lung benefits, Francis Perkins Building, Room N-2605, 200 Constitution Avenue, N.W., Washington, DC 20210.